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RESEARCH ARTICLE

Audit of a Mindfulness-Based Cognitive Therapy Course Within a Prison

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Abstract

This article examines the effectiveness of the 8-week mindfulness-based cognitive therapy course for depression within the prison population. Prisons see higher rates of mental ill health across the spectrum. This study examined how a manualized mindfulness approach to treating depression, a major cause of ill health, would affect this cohort. At the beginning of the course, participants were experiencing high levels of depression and anxiety, with low levels of mindfulness. At the end of 8 weeks, levels of depression and anxiety were reduced while mindfulness scores had increased, suggesting that mindfulness helped participants cope with difficult feelings and sensations. Retrospective study informed consent given by participants.

Keywords: mindfulness, group work, trauma, prisons, mental health

Introduction

This audit evaluates the effectiveness of an 8-week mindfulness-based cognitive therapy (MBCT) program conducted in a prison environment. It considers the value of running a similar program in the future, what lessons can be learned, and how the program could be improved. The impetus for this project originated from members of a prison-reading group, all of whom were serving sentences from a few months to several years. A lecturer from London South Bank University (LSBU) was asked to attend a book club for a professional mental health perspective on the topic of discussion. The value of mindfulness was raised, and participants were very keen to start up a mindfulness program within the prison. They believed that it would be a valuable tool in learning to cope with the stress of the prison environment and they were hopeful of learning new skills in dealing with life in general.

Table 1 gives a quick reference to levels of mental health, self-harm, and suicide within the prison population 2017/18 as compared with the general population, where numbers are available. In summary, incarcerated people are a group with a significant prevalence of pre-existing trauma and mental health problems, who are being incarcerated for longer periods in more crowded conditions. They are experiencing a concomitant increase in emotional distress and mental health problems, expressed through substance misuse, self-harm, violent incidents, and suicide attempts.

Background

The Environment

The prison population in England and Wales in May 2018 was 83,430 (Sturge, 2018). The same report highlighted that prisoners were receiving longer sentences, with 46% being over 4 years in 2018 compared with 33% in 2010. In addition, 58% of prisons were reported as being overcrowded, causing increased incidents of mental health problems and suicide (Huey and McNulty, 2005).

There was also a 13% increase in reported assaults from 2016 to 2017 (29,500 assaults), which in turn was 44% more than 2015. In addition, there were 8,429

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Table 1. Percentage of Prison Population With a Mental Disorder vs. General Population 2017/18 per 1000 Population

Mental disorder	*Male and female (%)*	*General population (%)*
Self-harm	81	—
Suicide	0.8	0.16
Affective disorders	40	16
Personality disorders	64	5
Psychosis	10	0.5
Multimorbidity	76	7.9
Substance misuse	49	—
Dual diagnosis	72	0.05

Her Majesty's Prison and Probation Service.

reported assaults on prison staff, with 864 being in the *serious* category (National Audit Office, 2017).

Mental Health

Mental health problems are common in people in contact with the criminal justice system. An estimated 39% of people detained in police custody had some form of mental disorder, and over 25% of residents in approved premises (previously known as bail hostels) had been found to have a psychiatric diagnosis (National Audit Office, 2017). Government does not know how many people in prison have a mental illness, how much it is spending on mental health in prisons, or whether it is achieving its objectives. It is, therefore, hard to see how government can be achieving value for money in its efforts to improve the mental health and well-being of prisoners, according to a report by the National Audit Office (2017). Her Majesty's Prison and Probation Service, National Health Service (NHS) England, and Public Health England have set ambitious objectives for providing mental health services but do not collect enough or good enough data to understand whether they are meeting them. This article includes several studies on trauma and post-traumatic stress disorder (PTSD), as numbers were not included in recent national prison audits (National Audit Office, 2017), and more information on suicide and self-harm as this is where our interests are.

Trauma

Howard *et al.* (2017) reported high rates of trauma in the prison population, with 97.8% of participants reporting having experienced traumatic events and 60.5% meeting DSM-5 criteria for a PTSD diagnosis. James and Todak (2018) found slightly lower rates of PTSD (19%) but stated that this rate was equal to that of soldiers who served in Afghanistan and/or Iraq. Finally, Baranyi *et al.* (2018) completed an analysis of data going back to 1980 and found that male prisoners had diagnosis rates of PTSD of between 0.1% and 27%, with the pooled rate being 6.2% (95% CI: 3.9–9.0). Stensrud *et al.* (2018) found that 65% of male sex offenders and 42.7% of low-risk incarcerated males in their study had experienced four or more traumatic events. This is higher than the normative average rate of 9.2% for males in the general population.

PTSD is seen as situational: being held hostage, witnessing violent deaths, and prolonged personal assault. Incarceration would fit this description for many prisoners, and our cohort would at times refer to their environment with real horror.

Complex PTSD is thought to be the more severe type of PTSD and is diagnosed when:

- traumatic events happened early in life,
- trauma was caused by a parent or caregiver,
- the person experienced the trauma for a long time, and
- the person was alone at the time of the trauma and there is still contact with the person responsible for the trauma.

It can take years for complex trauma to be recognized, and behavior, including self-confidence, can be altered as the child grows up. Symptoms include marked feelings of guilt or shame, difficulty in controlling emotions, periods of losing attention and concentration, physical symptoms, relational difficulties, and destructive or risky behavior such as self-harm, alcohol or drug self-medicating, and suicidal thoughts (National Institute for Health and Care Excellence, 2018).

Research on complex trauma is focusing on how the brain retains memory: essentially, there is explicit memory (conscious and verbal awareness) and implicit memory (unconscious sensory awareness; Rothschild, 2000). Sensory memory is central to understanding of traumatic memory. Individuals with complex trauma feel the memory of their trauma, the felt sense of it (implicit), but will be missing the awareness to make sense of this, the explicit memory of it. The world is experienced with a radically different nervous system (Ogden and Fisher, 2015; Rothschild, 2000; van der Kolk *et al.*, 2007), one that is continually wound up, leading to states of hyperarousal (seen through the lens of anger) or withdrawal.

Self-Harm

There were 44,600 instances of deliberate self-harm within the prison population between 2016 and 2017, a rise of 11%. These acts of self-harm were related to 11,600 individuals, a rate of 3.8 instances per individual. The rate of reported self-harm in male prisons has risen from 50% of reported instances in 2009 to 81% in 2017. The rate of males reporting self-harm has doubled in the 10 years to 2017 (National Audit Office, 2017).

Suicide

There were 299 prisoner deaths in 2017, of which 23% (69) were deemed to be self-inflicted, with 21% currently awaiting outcome. The self-inflicted death rate of 0.8 per

1,000 in the male prison population is significantly higher than the general population's rate of 0.16 per 1,000 (Prison Reform Trust, 2017).

Reoffending

The Prison Reform Trust (2017) identified that 47% of adults were reconvicted within 1 year of release from prison. For those serving sentences of less than 12 months, this increased to 58%. Nearly three quarters (73%) of under 18-year old children were reconvicted within a year of release. The impact of prison goes beyond the individual incarcerated; approximately 200,000 children in England and Wales had a parent in prison at some point in 2009.

The strongest dynamic predictors of any reoffending for men and women were class A drugs and binge drinking. The strongest dynamic predictors of violent reoffending were a lack of housing, being the victim of domestic violence (more women than men), problem drinking, weak family ties, binge drinking, and issues with temper control—the latter three being strongest predictors for women. All of the predictors correlate strongly with early childhood issues with attachment or early traumatic childhood experiences (Ogden *et al.*, 2006; van der Kolk *et al.*, 2007). Less than 1% of all children in England were in care but looked-after children[1] make up 30% of boys and 44% of girls in custody (Prison Reform Trust, 2013).

In summary, people who commit criminal offenses are a group with a significant prevalence of preexisting trauma and mental health problems, who are being incarcerated for longer periods in more crowded conditions. They are experiencing a concomitant increase in emotional distress and mental health problems, expressed through substance misuses, self-harm, violent incidents, and suicide attempts.

Mindfulness cannot address the wider socioeconomic antecedents to their situation, but it has potential to enable these individuals to find more adaptive ways to respond to their trauma and daily stresses.

What Is Mindfulness?

Mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1990) and MBCT for depression (Segal *et al.*, 2002) were developed as clinical interventions establishing mindfulness as a way to treat both physical and psychological symptoms (Baer, 2016; Creswell, 2017; Harrington and Dunne, 2015; Shapiro and Carlson, 2009). Since then, the popularity of mindfulness interventions has advanced into many other realms of Western medicine and psychology. The key difference between MBCT and MBSR is that the MBCT program has an explicit focus on turning toward low mood and negative thoughts early in the program. This enables participants to gain experience with recognizing these symptoms and confidence in their ability to respond skillfully.

MBCT is a proven care pathway for chronic depression in the NHS (National Institute for Health and Care Excellence, 2018). Mindful practice is concerned with changing the function or relationship with events. Teasdale (1999) suggested that sad moods reactivate thinking styles associated with previous sad moods. Previously depressed patients would be particularly vulnerable to this differential activation since they have relatively easy access to negative material (e.g., thoughts, attitudes, assumptions). MBCT focuses on thoughts as process rather than the content of individual thoughts. It seeks to help practitioners to develop the ability to step outside of negative thinking patterns by being mindful and to let go of the constant striving to escape unhappiness. This gives a quite different feel to the group dynamic and facilitates the idea of inquiry and journey as opposed to problem solving and resolving.

This change from *doing* (discrepancy-based model, used in striving to avoid/or achieve, with key qualities of rumination and problem solving) to a *being* mode (Williams, 2008) means that the key skills of mindfulness and mode change are awareness of what the current state of mind is and the ability to disengage from the dysfunctional modes of mind. This can best be explained by examining in more detail a mode of mind, rumination.

Many studies have shown that ruminations maintain or intensify depressive symptoms and impair problem-solving abilities (Bockting, *et al.*, 2005; Fava *et al.*, 1994, 1996, 1998; Hollon *et al.*, 2005; Jarrett *et al.*, 2000; Scott *et al.*, 2000; Teasdale *et al.*, 2000). The doing mode of mind (goal oriented, problem solving, and nonaccepting of how things are) is particularly damaging as it naturally seeks evaluations and judgments on body sensations and thoughts. Mindfulness, by engaging with being mode, fosters a decentered relationship with negative thoughts and feelings. Thoughts can be viewed as analogous to clouds in the sky. Just as clouds are not the sky, so thoughts are not the person. This approach encourages direct experience and intuitive wisdom. A mindful approach has been shown to be useful in both mental health and physical health disorders, and meta-analysis of standardized mindfulness practice showed that the evidence supports the use of MBSR and MBCT to alleviate symptoms, both mental and physical, in the adjunct treatment of cancer, cardiovascular disease, chronic pain, depression, and anxiety disorders and in prevention in healthy adults and children (Gotink *et al.*, 2015).

The Role of Mindfulness in the Criminal Justice System

The research on mindfulness in prisons primarily comes from the United States. This has found that mindfulness

[1]The definition of looked-after children (children in care) is found in the Children Act 1989 (United Kingdom). A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for >24 h.

is beneficial in reducing hostility and mood disturbance and increasing self-esteem and impulse control (Himelstein, 2011; Lyons and Cantrell, 2016; Samuelson *et al.*, 2007; Shonin *et al.*, 2013; Sumter *et al.*, 2009). Mindfulness has also been associated with a decrease in the rates of recidivism in youth and adults (Dafoe and Stermac, 2013).

Auty *et al.* (2017) completed a systematic review and two meta-analyses on the impact of mindful mediation and yoga for prison populations. They found a correlation between the intervention and improved psychological well-being and behavioral functioning of prisoners. Shonin *et al.* (2013) also completed a systematic review on Buddhist-derived interventions (BDIs) including mindfulness and noted the overall poor quality of available literature. They examined 85 articles but included only 8 in the review due to quality appraisal issues. Nevertheless, they concluded that BDI including mindfulness is an effective intervention for prisoners.

Simpson *et al.* (2018) reviewed the available literature for mindfulness treatments and youth who commit criminal offenses. They included 13 studies and concluded that the studies indicated that mindfulness improved mental health, self-regulation, problematic behavior, substance use, quality of life, and criminal propensity. Also focusing on the youth population, Murray *et al.* (2018) reviewed the literature for mindfulness and meta-synthesized 10 studies. They found that mindfulness could help reduce stress and anger and improve self-regulation and acceptance.

Yoon *et al.* (2017) conducted a systematic review and meta-analysis on therapy efficacy for prisoners with mental health problem, including 35 articles. They identified a medium effect size for most therapeutic interventions, with Cognitive Behavioral Therapy and mindfulness being the most efficacious, although they too noted quality issues in the available literature.

Zgierska *et al.* (2009) reviewed 25 articles and found that mindful mediation had a small effect in reducing substance misuse relapse. Subsequently, Moyes *et al.* (2016) reviewed the literature on prisoners with dual diagnosis and found that mindfulness is an effective treatment for those with low-level dual diagnosis.

The Mindfulness All-Party Parliamentary Group (MAPPG, 2015) also reported on the successfulness of mindfulness in prisons. They highlighted that mindfulness can be beneficial for prisoners for improving self-regulation and decreasing negative affect.

The prison service and prison population face unique pressures and issues. It is valuable to review the nature and magnitude of the challenges.

Method

Mindfulness Project Thameside Prison

LSBU was given the opportunity to engage with incarcerated males as part of a prison reading group and to provide a professional therapeutic voice in the discussion on depression, which was the central theme of the book being discussed.

The participants were curious to know our background and became especially interested in mindfulness. They were curious to know how it might help them and wanted to try out a group. Mindfulness is not a therapy: There was no stigma attached to their curiosity and emphasis was placed on this being something that could improve their experience of prison. The men initiated interest in the mindfulness project and pressed for the chance to have a group within the prison.

The LSBU mindfulness research group (LMRG) approached Thameside prison with an offer of a full week 8-week course of MBCT. These sessions were usually 2.5 hours in length, but also included a 6-hour silent day in week 6.

The decision was made to run an MBCT program rather than the MBSR as MBCT is more structured in the skills that are taught. These skills can help participants to lower rates of anxiety, depression, and suicidality. They would also learn to recognize when their mood was lowering and to be able to do something about this before it became too difficult.

Twelve participants initially attended. However, one subsequently left voluntarily and four were moved to other prisons. The remaining seven completed the program.

The initial program involved six stages:

Stage 1. LMRG met with a range of different agencies and service providers within Thameside to ensure that the MBCT program was explained and placed in context with the other rehabilitative and therapeutic activities.

Stage 2. LMRG began a screening and assessment process by which to identify prisoners who were appropriate for the MBCT course. Although the selection was designed to be as open as possible, there needed to be some exclusion criteria. These were applied to any prisoners who posed a major management risk of violence to others, who were actively psychotic, or who were actively struggling with issues of ongoing drug use or intoxication. These criteria were agreed between LMRG and Thameside itself, as otherwise there was a risk of breaching prison protocols. An initial 12 prisoners were selected. Although the ideal MBSR group does not always have a ceiling in terms of numbers, it is generally recognized that more than 20 is potentially problematic in the amount of time and attention that can be given to any single participant. LMRG negotiated 12 places with the prison to provide a compromise between the high demand and ensuring proper facilitation and risk (especially with the needs of this group of participants).

All participants were interviewed for an hour and a half for a comprehensive assessment. The interview

focused on current concerns or stressors and how these might be linked to current and past behavior. Health considerations were considered, and background and family history were noted. Employment history and forensic history were discussed, and participants were encouraged to talk about what had drawn them to the mindfulness course. Depression and anxiety ratings were taken, as well as mindfulness scales at the beginning and end of the 8-week course.

Stage 3. LMRG and Thameside organized the materials required for the MBCT group, including stools, blankets, CDs, and the printing of the MBCT manual.

Stage 4. This was the intervention stage in which the 8-week MBCT program was run (Table 2). The program uses mindfulness techniques such as body scans, mindful movement, and mindful sitting practice, commonly called meditation.

Stage 5. This stage was concerned with endings and reviewing the program, including rating scales and interviews. We also had a discussion panel with participants to talk about what might be useful changes to the program.

The feedback was overwhelmingly positive, with all participants remarking on how the program had improved their quality of life. They also spoke of how the practice had helped them adapt to their lives in new and more helpful ways, with a marked reduction in anxiety, low mood, suicidality, and despair. The positive feedback was very encouraging. It was noticed by staff that the participants were far more settled than before, and participants agreed with this. They also felt that their practice was acting as a role model to other prisoners. LMRG was encouraged to repeat the program and think about how the MBCT could be used to help prisoners across the spectrum of needs that they present.

Stage 6. Three months after the program ended, a follow-up and discussion group was held to ascertain the participants' reflections on the program—that is, what worked and what part of the program needed adjustments.

Table 2. Eight-Week Mindfulness-Based Cognitive Therapy Program

Week	*Topic*
Session 1	Awareness and automatic pilot
Session 2	Living in our heads
Session 3	Gathering the scattered mind
Session 4	Recognizing aversion
Session 5	Allowing/letting be
Session 6	Thoughts are not facts + all-day silent retreat
Session 7	''How can I best take care of myself?''
Session 8	Maintaining and extending new learning

Results

Participants expressed the view that the program needed to be longer as their circumstances were different from a more traditional depression group, with added difficulties in the type and range of emotion felt and issues around safety in the group.

They all considered that they benefited from mindful movement and that this was a breakthrough for them, in terms of noticing a reduction in hyperarousal states and generally helping with extreme aches and pains in the body. It was noted that this group had a quite different relationship with the body compared with other nonclinical groups, this relationship being typified by chronic pain. This was the sort of body response typified in a depression group but even more intense.

The guided practice tapes used standard language as heard in any MBCT group and the men had real issues with this. They believed that the language should be far more ''down to earth.'' However, this concern did not extend to the poems chosen. The participants really enjoyed the poetry chosen, even if it was difficult to understand at times or used an unfamiliar language style.

Participants who found that access to the guided practice was difficult as the promised CD players, needed to facilitate this exercise, did not all arrive.

Participants need to commit to practice to benefit from the program. The 8-week course asks that everyone engages in session and during the week. ''Homework'' is set, consisting of mindful practice. Mp3 downloads of guided meditations alongside practical tasks are set each week. Participants were asked to create dedicated time to ensure that these took place between session homework. An unexpected side effect of the environmental constraints of the prison meant that they were able to commit to the practice (by being so restricted), while also quickly noticing its value in helping them manage the ennui of the prison's lockdown regime.

One of the adaptations we had to make to the course as we were doing it was to increase its length from 2 to 3 hours, in line with the original MBSR program (Kabat-Zinn, 1990). Prison life is very regimented and the time we had to do the MBCT program had to fit in with prisoners' movements, allocated times when the population are given to move around the prison. Prisoners are not allowed to move freely and are given blocks of time before they are allowed to move from one part of the prison to the other. Extending the sessions maximized use of the block of time available and provided participants with more time to build trust.

Their feedback was that the 8-week course really helped them in the management of the stress and chaos of the prison regime and gave the long periods of lockdown a structure and purpose. They also reported that other prisoners observing their practice had become interested and they had shared their knowledge and learning

with them to promote practice on a wider scale on their prison wings. One group member had written an article in the prison journal of his experience, which stated that, ''…we were feeling common experiences such as anger, stress, loneliness, and depression. Once identified, we discussed how we could teach ourselves to cope with these feelings,'' and ''Accepting that you have no control over what comes into your head but knowing how to refocus was the breakthrough moment for me and has helped reduce my negative thoughts and emotions.''

Discussion

Mindfulness research in prisons has focused mainly on looking at differences in clinical states: reductions in depression, reduction in anxiety, as well as positive change, such as changes in recidivism, impulse control, suicide, and self-harm, with similar results for yoga practice (Auty *et al.*, 2017).

The decision to offer an MBCT rather than an MBSR program worked well as participants enjoyed a structured approach that taught them to look at how thoughts could influence their emotions. They learned to recognize at an earlier stage the importance of noticing warning signs that their mood was changing. This meant that they had the skills not to respond habitually but to create new patterns of being and, therefore, new neural pathways (Williams, 2007). At the follow-up 3 months later, participants reported still feeling improvements in the overall health and well-being.

In prisons, there is a much greater issue of trust. We found that 8 weeks, which works for the general population, is too short for the prison population; more time needs to be spent on making the group feel safe. Statistics show this cohort has a higher prevalence of severe forms of anxiety, depression, and trauma responses (National Audit Office, 2017; Prison Reform Trust, 2017).

We struggled with some of the exclusion criteria that we had intended to apply. In most MBCT groups, patients are seen in remission from depression and not actively suicidal. However, Barnhofer *et al.* (2015) have suggested that a mindful program is beneficial to participants who felt suicidal. After interviewing potential participants, we considered that it would make sense to include those with high levels of distress and suicidality.

The studies we reviewed did not seem to address the impact of trauma on the prison population and its effects on individuals. Observations were made that group members displayed these symptoms, and testimonials written by the men refer to a reduction in their feelings around suicide. The group members showed typical trauma responses such as hyperarousal, which translated into difficult body sensations and reduced thought processing (van der Kolk, 2015).

The process of trauma and the impact of early childhood attachment on the brain are slowly becoming more apparent, and this is beginning to inform practice. When we looked at research conducted by Travers and Mann (2018), we discovered key traits of trauma; at the top of the list was poor problem solving, closely followed by impulsivity, and followed by adverse childhood experiences. Poor temper control, binge drinking, and drug misuse were also high. The strongest dynamic predictors of violent reoffending for women included temper control, problem drinking, and binge drinking, alongside lack of closeness with family, all strong correlators for chronic trauma. The most prevalent criminogenic factors for women and men were poor problem solving, impulsivity, and unemployment (Travers and Mann, 2018). Within our group, we found that poor problem solving, impulsivity, and adverse childhood experiences were key to understanding our cohort's experience, closely followed by poor temper control and drug use.

Mindfulness teaches us to start being aware of what we are experiencing; it focuses on what is happening right now and encourages curiosity of the felt senses. However, because trauma response is grounded in the body, additional work involving sensory motor responses has been proven to be effective (Ogden *et al.*, 2006), as trauma is often the speechless terror (Etkin, 2015; Ogden *et al.*, 2006; Scott *et al.*, 2017; Wild and Gur, 2008). This is where the traumatized persons are reduced to silence and terror due to their body sensations being so overwhelming. Survivors of extreme traumatic exposure commonly exhibit difficulty recounting the terrible events they have suffered or witnessed. In our experience of the 8-week course for this population, yoga and yoga-based movement were successful and this may have been in part due to the cessation or reduction in body sensations as hyperarousal systems were processed.

The voice recordings proved to be a source of difficulty, with group members having difficulty accessing CD players. The inventive use of playing the recordings over the radio partly solved the problem but further difficulties ensued when the wrong recordings were played; there was also an element of ''Big Brother''—that is, mantras being chanted over a loudspeaker system to pacify a captive audience—about this arrangement (Orwell, 2008). The group members had no control over the recordings, and they would play on a spool, which participants had to tune into.

In line with the central tenets of mindfulness, the strongest impact on the group often came from what arises through the inquiry. Challenges that are met and worked with proved to have the strongest impact on the group, and topics for inquiry, including gender and sexuality, were particularly nuanced and rich. The challenges of

working with this population are not to be diminished; participants were at times argumentative and would try to push barriers. However, working with the edges of this in a mindful manner meant that challenges that were supposed to push boundaries became subjects of deep connection. Men who would try to use sexuality to provoke or ''get a laugh'' were instead allowed to become the subject of the guided practice. So, questions around what constituted masculinity connected deeply with their experience.

Mindfulness is not an easy choice; it entails hard work. It is a behavior-driven way of being that can require someone to be at ''rock bottom'' before they are able to fully immerse themselves in it. This makes it highly appropriate for the prison population. We found that homework, so often a source of difficulty in practice, became a source of comfort for participants and the difficulty was finding a safe space rather than time to practice. This was a group where participants would learn new life skills and we felt it was extremely important that members would be able to help co-run the group, and eventually run it, maybe setting up a prison mindfulness program. With this is mind, it became important to think about length of sentence and so, as part of our inclusion and exclusion criteria, it was important to have a sentence of no less than 1 year. This would enable participants to engage in at least one group as an active participant and then receive a week's training (like mindfulness students receiving their first-level teacher training qualification) and begin to coteach other groups.

Limitations

This was an audit of a single program in one establishment; consequently, generalizations need to be treated with extreme caution.

Recommendations

The following points would enable similar programs to be run more effectively in the future:

- All attendance should continue to be voluntary.
- Where possible participants should be allowed to complete the course and not moved to other prisons.
- The program should accept participants who were actively feeling traumatized, anxious, depressed, and suicidal.
- Pre- and postratings assessing mood should be taken weekly.
- The group facilitators should work closely with prison staff regarding risk.
- Care should be taken to use language that is accessible to all group participants.
- Access to a CD player must be a priority for participants.
- The course needs to be 12 weeks to allow for longer orientation; trust building; and exploration of trauma, impulse control, building resilience, and social awareness.
- Group members who wish to become facilitators should undergo a period of training.
- Sessions to be increased from 2 to 3 hours.

In addition to the MBCT 8-week program, we then considered that such was the presentation of the prison population (Travers and Mann, 2018) that additional weeks that incorporated elements of self-compassion therapy (Gilbert, 2010) and dialectic behavior therapy should be included, as well as an extended sensory motor approach to the group.

Conclusion

There is a real need to further refine the teaching of mindfulness for particular populations (MAPPG, 2015). The available evidence suggests that mindfulness-based interventions can be effective for justice-involved men and women and male youth for a variety of social and psychological difficulties. (There is a lack of research available for understanding the role of mindfulness in female youth.) The social and psychological difficulties treated include depression, anxiety, and poor social skills, but the literature can perhaps be best summarized as finding a link between mindfulness and improvement in prisoners' quality of life.

However, this conclusion should be tempered by the poor quality and heterogeneous nature of the available research. This reduces the generalizability of the studies and makes it difficult to draw firm conclusions on the effectiveness of mindfulness in the prison population. Research around trauma and how this links with perpetuating behaviors linked with criminal activity is particularly poor, and robust research in this area would be of great interest.

This study has demonstrated proof of concept for this initial project and we recommend that a sustainable continuous program of mindfulness be established in prisons. It can help people find their place, accept responsibility, stop feeling fear, and fulfill their rightful potential.

Authors' Note

Research on the prison population can be found at the National Audit Office and useful research on factors inhibiting recidivism at the Ministry of Justice site. Work on trauma and psychomotor responses and neurology can be found in the studies of Pat Ogden, Bessel van der Kolk, and Babette Rothschild. Clinicians interested in working with trauma body response should contact Jill Satterfield: www.schoolforcompassionateaction.org.

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